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ABSTRACT

This document discusses the role of the psychiatrist in the military service. An historical overview of psychiatric utilization in the military is presented and criticized. A psychiatrist may be required to function in any or all of a number of roles--therapist, investigator, administrative officer, evaluator, consultant, and teacher. The differences in the requirements between a military and civilian psychiatric practice are so great as to mitigate for a different conceptual framework, possibly with a different professional designation. The author suggests that the recognition and understanding of the following factors are critical to a successful and satisfying professional experience by a psychiatrist in the military: (1) allegiance is to the military rather than to the patient; (2) there is a lack of confidentiality in the military; (3) there may be distortion of transference caused by the psychiatrist being an officer in uniform; (4) a primary objective of intervention is to return the patient to duty; (5) the Psychiatric Military Officer may exert significant control over the career and life of his patients. The psychiatrist and his Air Force clientele will best be served if they understand and accept the above limitations. (Author/PC)

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PSYCHIATRY AND THE AIR FORCE: AN UNEASY ALLIANCE

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FOREWORD

The material for this paper was drawn essentially from two areas: A review of the literature and observations made as a member of the active and reserve military forces for more than twenty years, the major part of which was spent in the Air Force Reserve and Air National Guard as a Medical Service Corp Officer.

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Background

With the possible exception of organized religion and the university, few institutions in the United States approach the military in established and continuous tradition. The notes that sound retreat at an Air Force Base of today echo the strains that sounded over Civil War camps and at forts in Indian territory over a century ago: Many military ideas and precepts have remained almost as unchanged. "The military is not only the nation's largest bureaucracy but it is probably the most entrenched and the least amenable to confrontation or to change" Adam Yarmolinsky observes in his book The Military Establishment.

The uniformed military is an island of authority and conformity in an increasingly permissive society. For its members it prescribes, within relatively narrow limits, a strict standard of dress, grooming and behavior. It assigns to the individuals therein where they will live, the work they will do, and it alone controls advancement within the structure. The mission and goal of the military transcends the desires and sometimes the needs of the individual; this is not done heartlessly but because the nature of the institutional mission requires it. The average citizen often fails to realize that the military performs its assigned functions at the direction of Congress and the President, its Commander-in-Chief. A civilian secretary heads each service and the military budget is decided by Congress.

Often military training, discipline and duty clash with the democratic and equalitarian values of civilian society in a number of ways. The military is group, rather than individual oriented; it requires unquestioning patriotism (of its own definition), and instant and unquestioning response to command. This can (and often

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does run counter to the individualistic, inquiring and humanistic ideals of the civilian society.

The military is a dynamic organization, however, which continues to attempt to respond to pressures for a more liberal and civilian-type environment. But it is hampered by indecision as to what changes can be made without jeopardizing its reason for being; how the services can be liberalized yet still maintain the level of efficiency and effectiveness consonant with the requirements of its prescribed mission.

Examples of change within the military are particularly apparent in the Air Force. Mandated by Congress as a separate service in 1947, it has unquestionably benefited by a lighter hand of tradition in virtually all areas. Airmen typically live in rooms designed for one or two, pay begins at $326.10 per month plus food, housing, clothing and medical and dental care, and advancement is generally good. After four years of service, enlisted personnel can expect to be making over $400 per month in addition to the "fringe" benefits described above.

The differences between civilian and Air Force life are fewer than the average civilian would expect. Compared to the other military services there is a minimal awareness among the population of an Air Force Base that they are part of a "war" machine. With some notable exceptions, an Air Force Base resembles other types of socio-cultural communities such as religious orders, large medical centers or even colleges. The similar institutional characteristics include common goals, given priorities, and a bureaucracy highly stratified and heirarchal in nature and oriented to respond without question quickly and collectively to appropriate emergency situations, real or simulated. The parallels between the organizational structures are very similar in the personnel area.

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Whether a member of the Air Force or management level employee of a major corporation, a condition of continued affiliation is a willingness to move regularly as the needs of the organization require. The path to upward mobility is equally clear in both organizations: consonance with the value system and general goals of the unit, willingness to seek additional training and take greater responsibilities.

In many ways the military situations are professionally advantageous. It is a more "open" society, much less discriminatory because of color, race or religion. The way to upward mobility is clear and the rules "spelled out" in terms of required levels of competency, personal behavior and education. The military, unlike most of their civilian counterparts, will provide necessary or desired professional training either within the Air Force or at a civilian institution.

The Air Force is also more stable than most civilian corporations. It can assure long-term employment with excellent fringe benefits and an excellent retirement package. Military personnel are less subject to economic fluctuations than the civilian community. If the military budget is cut, there is sufficient notice, and the size of the institution is large enough, so that the personnel involved can be transferred or cross-trained. The military service generally recognizes its legal and ethical responsibility to its members to a much greater extent than is the case with the private economic sector.

In summary the Air Foce, like other military services, has a subcultural identity. Its tradition contributes to stability and its relationship and contribution to the main culture are clearly established. It has a specifically defined goal, standards for membership, a system of hierarchies, and it demands satisfactory group performance as the

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price of advancement. This then is the setting within which psychiatry is practiced in the military.

Historical overview of Psychiatry and the Military

Military leadership has not always recognized the potential contribution of psychiatry to the service setting and the coincidence of psychiatry and tne military has not always been harmonious.

In the Naval Medical Bulletin at the close of World War I there appeared an editorial (almost certainly having had to have had the concurrance of tne Surgeon General) which suggested that while psychiatrists had been useful in getting the mentally retarded out of the service, when peacetime came there would be no place for psychiatry in Navy Medicine.

The years between World War I and World War II saw little expansion of psycniatry within the military. The military budget was minimal, priorities for medical practitioners were higher in other areas and tne relatively low pay of military surgeons attracted few psychiatrists.

At the beginning of World War II, William C. Menninger, a well known psychiatrist, was appointed a Brigadier General and made Chief of tne Neuropsychiatry Consultants Division. In addition to this recognition of the profession, psychiatric utilization was made in the following five areas:

1. Selection of recruits. As a result more than 850,000 men were rejected for psychiatric reasons.
2. Detection and separation of psychiatric military risks. It is of note that 45% of all discharged during World War II were for psychiatric reasons.

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3. The treatment of psychiatric casualties at all levels of training and action.
4. Planning the rehabilitation of psychiatric casualties returning to civilian life.
5. Psychiatric consultants to commanders serving at all levels for mental health and morale.

Since World II relatively more psychiatrists have been recruited to the services: this is to a great extent the result of provision for residency training in psychiatry while on active duty. There has always been a shortage of trained psychiatrists in service and many physicians called to service have found themselves required to practice that specialty with no more training than was received in their rotating internship and/or general residency.

Another inhibiting factor in the application of psychiatry in the military has been the attitude of the military leadership. Service personnel are supposedly men of uncommon strength and self-reliance in all areas, physically and mentally. It follows that any one not able to handle their own problems ought not to be in the military. For these and other reasons psychiatry has played a relatively minor role in the military services.

The Psychiatrist in Uniform

There are great differences between the role and function of a psychiatrist in the military service and civilian psychiatric practice. The role of the psychiatrist in the military is ambiguous and multi-dimensional--he may be required to function as a therapist, investigator, administrative officer, evaluator, consultant or teacher. His primary allegiance is to the military; service to the patient must be in terms of the mission of the unit.

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In contrast to civilian practice, where the patient is usually self-referred, the military patient may be ordered to report to the psychiatrist by the person's commander or other authority.

The civilian psychiatrist has little control over those factors immediately influencing the patient's life such as his job, where he lives, etc. The military psychiatrist can have a great deal of control. His is often the decision to recommend the person remain in service or be separated, be approved for security clearance or for the human reliability program, or be transferred to another position, or trained for another occupation. The authoritarian nature of the Air Force limits the patient's freedom to make decisions for himself.

While confidentiality is an absolute in civilian practice, it cannot be promised in the military. A superior officer with "a need to know" must be given requested information including access to records. This is justified on the basis of assigning responsibilities: there is the potential of an unstable person endangering the lives, health, and welfare of large numbers of people. (Curiously chaplains and legal officers have privileged communication status but psychiatrists do not.)

The concern that anything said to the psychiatrist could negatively influence their career is a realistic one. The problems of establishing a theraputic alliance can be numerous and formidable. The "needs of the service" may at any time require a temporary or permanent change of station for either the patient or therapist.

In a rank-conscious group, the difference in rank may cause problems of relationship and in the transference phenomena. The younger patient may be inhibited in relating to a superior officer, the older, higher-ranking patient (officer or enlisted man) may question the lack of

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experience of a younger or lower-ranking therapist. In defending itself against criticisms of this system the military pleads a much larger purpose than the emotional well being of the individual airman and officer. As long as military forces are needed, that defense possesses a certain logic. The mission of Air Force psychiatry is to serve the mission of the Air Force, not the individual. The individual is seen by the military as part of a team, the effectiveness of which is threatened by the ineffectiveness or loss of any member. Thus the psychiatrist's role is to restore the health of the unit by bracing its weak spots. In the end, this position is justified only if the military service itself can be justified.

There are other factors complicating the effectiveness of a psychiatrist in the military. The role and function of any person in the Air Force is to a great extent dependent on the particular unit and its mission as well as the commander's predispositions to commanding that organization. A commander, medical or otherwise, who has a limited regard for the mental health professions can and does limit the effectiveness of those professions in a variety of ways, the most obvious of which is to ignore them.

The orientation of a military commander can generally be grouped into one of three categories:

> The "Get 'em Out" group wants any deviant individual out of their organization, sometimes with what seems to be a concern for epidemiological factors, ("Whatever it is they have I don't want the other men to catch") and this is sometimes coupled with a mania for making an example of the person.

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A second group is the "Give us a way out with this guy." They may not be willing to keep them in their outfit but will try to find a way to transfer or discharge them in the least punitive manner.

The third group is the "salvage them" group, fortunately in the majority. They recognize the mutual coincidence of good for both the individual and the unit and will extend every effort to effect a mutually satisfactory disposition of the case.

There has been, in recent years, a major division within the services, between the "lifers", (career people) and the "short-timers" (those who chose to serve their military obligation with the Air Force rather than be drafted). Power and control within the service is vested with the career people, some of whom look upon the "short-timers" with disdain and treat them accordingly, assigning them the less desirable tasks and responsibilities.

Many psychiatrists in service fall into the "short-timers" group. They're in the Air Force for a two-year period and not always happy about being a part of the military. The frustration of being in service (and possibly struggling with his own military superiors) may lead the therapist into identifying with the patient and unconsciously encouraging him to act out the feelings of the therapist.

Usually the two-year psychiatrist begins his active duty upon completion of his residency, at the point where he is synthesizing the various aspects of his training and is ready to begin private practice. More often than not he has felt at some level of consciousness or unconsciousness that something would occur to preclude the required active duty. Instead of beginning in his new profession on his own

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terms, he's required to begin on some other quite different terms over which he has minimum control.

In a study reported by Sullivan, a clear relationship was demonstrated between the medical judgement "fit for duty" and personal values of a group of psychiatrists in the military. Those in agreement with the goals of the institution found 28% of their patients "fit for duty"' those not in agreement found only 18% of their patients "fit for duty."

Mental Health Problems in the Air Force Community

The kinds of problems seen in the mental health clinic on an Air Force Base are similar to those seen in civilian life but with some predictable differences because of unique or particular stresses imposed by military life. These would be family problems caused or aggrevated by tne father/husband being away for extended periods, people taking absence without leave, problems of military discipline, alcoholism, acting-out teen-agers and younger service members wanting "out" of the military.

The average military family moves about every three years; not necessarily to a place of their choice, but to where the serviceman is needed. After several of these moves there may be a philosophical acceptance of the situation but, as anyone who has moved a family will report, it's almost always a trying experience to uproot the family and move to a very different geographical location with all of the implications for family and social life, school changes and the leaving of what has been "home." Some wives and children make the adjustments without difficulty, otners become upset and/or depressed. This may result in serious disruption in family relationships, marital difficulties and acting-out children.

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An Air Force husband may be sent away for temporary duty for thirty, sixty, or ninety days. He may get lonely and find extra-marital companionship. As the lyrics of a tune from "Finian's Rainbow" phrases it, "When I'm Not Near The Girl I Love, I Love The Girl I'm Near." The relationship may grow with resulting emotional turmoil when the time nears to return home. In the meantime the lonely wife may need some comforting and help with the lawn or car or something, not surprisingly there's usually someone around to fill that void too. It is not unknown for that kind of situation to go beyond the bounds of platonic friendship.

Another area of stress in the Air Force is illustrated by the promotion pyramid. For both officers and airmen advancement beyond the lower levels is very competitive. In the officer corps virtually every second lieutenant will be promoted to first lieutenant. Beyond that however the number of available positions at the next highest rank is almost always significantly smaller than the number of people competing for those positions. While promotions are generally based on past job performances and demonstrated potential, when two equally qualified men are being considered, the decision may be influenced by the wives' activities in various social or service groups such as the Officers Wives Club, Boy or Girl Scouts, Little League, etc. Some wives enjoy this, others find it a self-imposed but dreaded duty.

The pressure to have a model (conforming) family with the boys sporting short, military-type haircuts, and the girls resplendent in skirts and wearing brassieres under their starched and ironed blouses often precipitates anti-social behavior on the part of the children, especially in the adolescent phase of development. Typically the boys

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are involved in petty thefts or malicious mischief while the girls act out sexually. The family is usually seen in the Mental Health Clinic only after the "crime and punishment" process has been imposed and found wanting.

For many of the younger airmen, the service is their first time away from home, family and friends. They find themselves in an alien environment in every respect. Most adjust without outside assistance, some are unable to and find their way to the Base Mental Health Clinic.

A common problem situation develops when a young person of seventeen or eighteen enlists for the minimum Air Force period of four years. After a year or so they decide that the Air Force is not for them. They've changed and they want out. From the institution's point of view the individual contracted voluntarily, was given expensive training, and is needed to fulfill the mission of the institution. While they can apply for discharge, it's a rather long and difficult process. To make it easy to get an acceptable type of discharge would jeopardize the stability, and concomitantly the effectiveness, of the institution. So the young man can try to make himself "undesirable." This generally includes (but is not necessarily limited to) being late or absent for duty because of any one or a combination of the following: (a) he overslept, (b) he thought he was off that day, (c) thought he wasn't needed, (d) went to the Dispensary, (e) his car broke down.

Since most military functions require temporal continuity, the person they were supposed to relieve may have to work a double shift or others have to assume an increased work load. The collective indignation (sometimes wrath) of this young man's colleagues reaches the supervisor who after exhausting his meager counseling techniques reverts to

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the traditional extra-duty/punishment methods. Several months later he decides that the military is better off without the individual and recommends a non or minimally punitive discharge. But the number of these discharges reflects on the efficiency and effectiveness et al of the Base Commander who is hopefully on his way to a bigger and better command.

Invariably the situation is referred to the Mental Health Clinic for a determination and a psychiatric examination ordered. The problem here is that it is not a simple matter to determine the strength of beliefs of an individual or to separate malingering from actual distress. A further problem is that the psychiatrist's boss, the Medical Commander, is not immune to pressure from the Base Commander to keep recommendations for discharge to a minimum--(the Base Commander signs his Effectiveness Report and he too would like to go on to bigger and better things.) The resulting pressure on all concerned can reach crisis proportions.

In the Air Force, military personnel within the continental U. S. with a psychiatric problem requiring hospitalization, are generally treated at one of six Air Force Medical Centers, each center serves a number of bases and stations in a given geographis area. These centers are generally well staffed and provide excellent services. Less severe problems are treated at the base level by psychiatrists, clinical psychologists, social workers, psychiatric nurses and mental health technicians.

To handle the mental health problems of the approximately 635,000 Air Force military personnel worldwide there are the following personnel. (As of February, 1974)

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		Authorized	Assigned
1.	Psychiatrists	141	107
2.	Clinical Psychologists	73	45
3.	Social Workers	96	92
4.	Psychiatric Nurses	141	153
5.	Psychiatric Technicians - on Wards	261	300
	Psychiatric Technicians - in Clinics	320	328

(The above data was supplied by the Air Force office of Medical Military Personnel, Randolf Air Force Base via phone on March 14, 1974.)

The psychiatric technician personnel range from well-trained to virtually totally untrained. The Air Force has no formal school training program for the mental health technician and this group is expected to get on-the-job training and supervision from the usually already over-worked professionals on the staff.

A further factor affecting Psychiatric Service is that due to the chronic shortage of physicians in the Air Force, psychiatrists are sometimes required to be medical officer-of-the-day (MOD) or assigned other related duties further limiting the time they have to practice their specialty.

Few bases ever have the number of mental health professionals they are authorized. Sometimes the Air Force contracts with civilian psychiatrists to augment the mental health staff and sometimes dependants are authorized treatment by civilian professionals or agencies.

On balance however my observation has been that the average Air Force community has better and more readily available resources to deal with mental health problems than the average civilian community, admittedly that says little in relationship to need.

As mentioned previously, a psychiatrist in the military is in a

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multidimensional role; he may be required to function in any or all of a number of roles, therapist, investigator, administrative officer, evaluator, consultant and teacher.

The differences in the requirements of a military and civilian psychiatric practice are so great as to mitigate for a different conceptual framework, possibly with a different professional designation. Such a framework has been suggested by two Navy psychiatrists with extensive experience, Barr and Zunin. They suggest that a comparison of techniques, methods and goals of psychiatry between military and civilian life is quite inappropriate and that the term Military Psychiatrist should be dropped in favor of the more accurate designation Psychiatric Military Officer.

As Bach points out, the difference is more than semartic. "The emphasis is changed from looking upon the work as a sub-specialty of psychiatry to looking upon these duties as a unique type of military service."

It is suggested that the recognition and understanding of the following factors delineated by Barr and Zunin are critical to a successful and satisfying professional experience by a psychiatrist in the military:

1. Allegiance is to the military service rather than to the patient.
2. There is a lack of confidentiality in the military.
3. There may be distortion of transference by the psychiatrist being an officer in uniform.
4. A primary objective is to return the patient to duty.
5. The temptation to confuse the patient's frustrations with his own may interfere with treatment.

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6. The Psychiatric Military Officer may exert significant control over the career and life of his patients.

In summary, the weight of evidence seems to suggest that the practice of psychiatry in the Air Force differs qualitatively from civilian practice to a degree that the designation should be changed to Psychiatric Military Officer with recognition by all concerned of the implications of the change in nomenclature. The psychiatrist and his Air Force clientele will obviously best be served if the limitations of this position are understood and accepted by the psychiatrist and his patient.

For the psychiatrist entering the Air Force, a thorough orientation to the institution is a necessity so that a clear definition of role and function may be established, as well as an understanding of the possibilities and limitations of patient treatment.

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